

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10285  
Registrar's No. 366

Registration District No. 85

Primary Registration District No. 1001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 WEEK  
(Specify whether  
In this community 40 YEARS  
years, months or days)

3. (a) PRINT  
FULL NAME

Joseph G. Tradway

3. (b) If veteran,  
name war No

3. (c) Social Security  
No. NONE

4. Sex MALE  
5. Color or  
race Wht

6. (a) Single, widowed, married,  
divorced SINGLE

6. (b) Name of husband or wife

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased FEB. 15 1888  
(Month) (Day) (Year)

8. AGE: Years 52 Months 1 Days 15 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Johnson City, TENN.  
(City, town, or county) (State or foreign country)

10. Usual occupation Labourer

11. Industry or business

12. Name ANTONIE TRADWAY  
13. Birthplace UNKNOWN TENN.  
(City, town, or county) (State or foreign country)  
14. Maiden name ANNIE GOREY  
15. Birthplace Memphis TENN.  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. MINNIE D. HINES  
(b) Address 2414 S. 4 St Joseph

17. (a) BURIAL (b) Date thereof April 1, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ASHLAND CEMETERY

18. (a) Signature of funeral director ELEMAN & SON, INC.

(b) Address St Joseph, Mo.

19. (a) April 1, 1940 (b) E. J. Westhues  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan  
(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2414 S. 4th.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR day 30th  
year 1940 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from March 23  
\_\_\_\_\_, 1940, to March 30, 1940,  
that I last saw him alive on March 30, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chronic Nephritis  
Uremia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations ✓

Of autopsy No

22. If death was due to external causes, fill in the following: n

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 7th

(c) Where did injury occur? 7th  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
85

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Robert W. O'Carroll (M. D. or other) \_\_\_\_\_

Address St Joseph Mo Date signed 3-30-40

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*C. G. Swan*

Licensed Embalmer No. 4082

P. O. Address.....

*St Joseph*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**